# No. 11139

IN THE

# UNITED STATES CIRCUIT COURT OF APPEALS

FOR THE NINTH CIRCUIT

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COMMERCIAL CASUALTY INSURANCE COMPANY,
a New Jersey corporation,

*Defendant-Appellant,*

vs.

LESLIE O. FOWLES,

*Plaintiff-Appellee.*

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UPON APPEAL FROM THE DISTRICT COURT OF THE UNITED STATES FOR THE EASTERN DISTRICT OF WASHINGTON, SOUTHERN DIVISION

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## BRIEF OF APPELLEE

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## STATEMENT

The Appellee, Leslie O. Fowles, insured herein, instituted this action against the appellant, Commercial Casualty Insurance Company of New Jersey, insurer herein, in the District Court under the Federal Declaratory Judgment Act (Sec. 274, 28 U. S. C. A. Sec. 400) alleging diversity of citizenship, a justiciable con-

troversy as to the meaning and construction of the policy in question, total and permanent disability and that the value of the rights he was seeking to preserve and protect exceeded the jurisdictional amount.

Insured in this action was injured in an automobile accident April 14, 1943, and has been continuously and totally disabled from that date. Due notice and proof of injury were given to the insurer but no offer of payment, either in the amount demanded by insured or the pro-rated amount alleged to be due by insurer, has been made.

The insurance policy involved herein was issued to the insured at Olympia, Washington, by the insurer, the Commercial Casualty Insurance Company, on or about May 5, 1937, upon insured's application therefor and in consideration of the payment of the semi-annual premium of $10.20. The policy was a life and accident policy designated as Star Accident Policy No. 14H 5110. That said policy of insurance by virtue of renewals thereof, remained in full force and effect herein.

That said policy provided, among other things, for the principal sum of $1000 payable upon accidental death; $25 per week disability benefit for loss of time resulting from accidental bodily injury from the date of any accident causing continuous total disability

which would prevent insured from performing each and every duty pertaining to his occupation; $100 identification disability; and the further additional benefit of $25 per week for fifteen consecutive weeks if such injury, within ninety days, necessitated treatment and residence in a hospital.

That at the time insured made application for said policy of insurance, his occupation was that of mail carrier in the postal service of the United States in the city of Olympia, Washington; that at said time, insured was, and had been for a number of years, a member of the Washington National Guard; that the Washington National Guard was mobilized in 1941, and later made a part of the Army of the United States, which facts were known to insurer's agent, Bader (Tr. 93).

Insured was on leave or furlough at the time of his injury and engaged in recreation. Insured duly notified insurer of said accident and submitted proof that he was totally disabled. The insurer failed to pay the benefits due under said policy of insurance and eighteen months later, October 11, 1944, insured began this action. The insurer moved to quash summons and service of the complaint and demurred thereto on the ground that the jurisdictional amount was not involved. On the 16th day of January, 1945, the insured

filed an amended complaint, and the insurer again moved to quash and demurred. A hearing was had and the trial court treated the motion to quash as a motion to dismiss, and the demurrer was overruled and the motion to dismiss denied on April 11, 1945.

On April 26, 1945, insurer filed its answer alleging the Federal court had no jurisdiction because the amount in controversy did not exceed $3,000, that there was no justiciable controversy, and that the insured had changed his occupation to one more hazardous, that of officer in the United States Army, which was classified by insurer for rating purposes as "Class K." In paragraph III of the affirmative defense in said answer, insurer sets forth that "Class K" provides a principal sum of $500, and a weekly indemnity not to exceed $5.00 and that in pro-rating any claim the limits referred to would be strictly adhered to. Insurer maintains in paragraph V that because of such purported change in occupation, that it is obliged to pay to the insured a sum not in excess of $5.00 per week for the period during which insured was confined in a civilian hospital.

Insurer in its answer alleged further that on or about September 15, 1932, it filed its manual containing the classification of risks of various occupations for insurance purposes, with the Insurance Commissioner

of the State of Washington, and alleged that at all times thereafter it was on file with said insurance commissioner, which insured denied.

The case was tried without a jury in the district court on June 15, 1945, before the Honorable L. B. Schwellenbach.

The Court found in favor of the insured upon the basis of the case of *Nordin vs. Commercial Casualty Company*, 176 Wash. 59, 28 P. (2d) 259, upon the ground that insurer had failed to establish the fact that it had filed with the Insurance Commissioner of the State of Washington, a copy of its classification of risks pertaining to the policy in suit, the Star Accident Policy No. 14H 5110, Cas. A. & H. 5643 as required by the laws of the State of Washington, Rem. Rev. Stat. Sec. 7233. The court held that, in view of such decision, it was not necessary to pass upon the question of alleged change of occupation or estoppel.

Thereafter, and on June 22, 1945, Findings of Fact, Conclusions of Law and Judgment were entered calling for payment of $25.00 per week with interest from date of accident until date of trial, and the further sum of $112.50 as hospital indemnity.

A motion for new trial was made by the insurer and overruled by the court. Notice of appeal was filed on the 25th day of July, 1945.

ARGUMENT



## ARGUMENT

### I. Judicial Discretion and Liberal Construction

It has been repeatedly held: That a declaratory judgment proceeding is neither wholly a suit in equity nor an action at law, but *sui generis*, and should be liberally construed. It may veer toward equity or toward law, but the underlying principle of the declaratory judgment is equity, and the granting of it should rest in the sound discretion of the court, as the remedy of declaratory relief, while created by statute, is one based largely on equitable consideration. (Construc-

tion and interpretation of written instruments are the principal functions of a declaratory judgment and was intended to allow declaration of rights whether or not other relief was asked. It contemplated not a mere determination of questions which may have arisen between the parties but an affirmative declaration of plaintiff's rights.) That the granting of declaratory relief under this section should rest in the court's discretion is implied from the fact that the act merely gives the court power to grant the remedy without prescribing conditions under which it is to be granted.

> "While the Federal act does not expressly provide that the granting of declaratory relief shall rest in the Court's discretion, this is clearly implied * * * *" *Aetna Casualty & S. Co. vs. Quarles*, 92 F. (2d) 321, 324.

142 A. L. R. 19.

> "The exercise of discretion to assume or refuse jurisdiction to make a declaration is said to depend upon whether the declaration will serve the purpose of the statute to clarify and settle the legal relations in issue."

In *Lumbermen's Mut. Casualty Co. vs. McIver*, 27 F. Supp. 702, 706, the court held:

> "It is well established law that the granting of a declaratory judgment lies considerably within the discretion of the court, after mature consideration of all the circumstances of the case."

It was said in *Mutual Life Ins. Co. of New York vs. Krejci*, 123 F. (2d) 594, that the jurisdiction granted by Congress under the declaratory judgment act is not to be exercised or denied at any whim of the trial court.

142 A. L. R. 58 states that a declaratory judgment involving the determination of questions of fact does not preclude its application, since the courts have the power to determine questions of fact when necessary or incidental to the declarations of legal relations.

Courts have the power, in actions for declaratory judgments, to determine questions of fact when that is necessary or incidental to the declaration of legal relations.

## II. Controversy

Under the provision of the Federal Declaratory Judgment act, the Courts of the United States shall have power to declare "rights and other legal relations of any interested party petitioning." *Maryland Cas. Co. vs. United Corp. of Mass.*, 29 F. Supp. 986.

In the present action, the justiciable controversy relates to the *meaning* of the policy and also as to the *validity* of the policy, but insurer denies that a controversy exists as to the meaning and validity of the policy. (Paragraph XI of insurer's Answer.)

The portions of the policy in which the meaning is in controversy and a summary of the controversy are as follows:

1.

PRINCIPAL SUM. It is the position of the insured that the death clause in an accident policy is life insurance within the meaning of the state statute providing that life insurance shall be incontestable after a certain period, but the insurer is attempting to reduce the face value of the policy.

2.

HOSPITAL INDEMNITY. The trial court construed the meaning of Schedule VIII. The insured alleged he was entitled to be paid for the full fifteen weeks he was confined in a hospital while the insurer contended insured was entitled to only the time in a civilian hospital, four and one-half weeks. Schedule VIII, providing hospital expenses provides:

> "If such injury to the Insured shall entitle him to weekly indemnity for total disability under the terms of this policy and within ninety days from the commencement of disability shall necessitate treatment and residence in a hospital, the Company will pay, in addition to the indemnity otherwise provided for a period not exceeding fifteen consecutive weeks, during which time the Insured shall be necessarily confined in the hospital, the amount for hospital expense but not exceeding

per week the amount payable hereunder as single weekly indemnity."

The language providing for Graduate Nurses fee is as follows:

"(Schedule IX) If such injury to the Insured shall entitle him to weekly indemnity for total disability under the terms of this policy and within ninety days from the date of commencement of said disability, the Insured shall need and receive the care and attendance of a nurse who is a graduate of a licensed hospital, and provided no claim is made for hospital expenses, the Company will pay to the Insured the amount actually and necessarily expended by him to secure such nurse's care and attendance, for a period not exceeding fifteen consecutive weeks but not exceeding per week the amount payable hereunder as single weekly indemnity."

It will be noted that in the latter provision it is stated "the amount actually and necessarily expended by him." This was not the wording of the hospital expense provision. If the company had intended to limit the hospitalization indemnity to the actual amount expended, it could have so provided.

3.

CHANGE OF OCCUPATION. In view of the numerous actions involving this one clause, there can be no doubt that it is generally controversial. It reads:

"This policy includes the endorsements and attached papers, if any, and contains the entire con-

tract of insurance except as it may be modified by the Company's classification of risks and premium rates in the event that the Insured is injured after having changed his occupation to one classified by the Company as more hazardous than that stated in the policy, or while he is doing any act or thing pertaining to any occupation so classified, except ordinary duties about his residence or while engaged in recreation, in which event the Company will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rate but within the limits so fixed by the Company for such more hazardous occupation.

"If the law of the State in which the Insured resides at the time this policy is issued requires that prior to its issue a statement of the premium rates and classification of risks pertaining to it shall be filed with the State official having supervision of insurance in such State then the premium rates and classification of risks mentioned in this policy shall mean only such as have been last filed by the Company in accordance with such law, but if such filing is not required by such law then they shall mean the Company's premium rates and classification of risks last made effective by it in such State prior to the occurrence of the loss for which the Company is liable."

The insurer alleges insured changed his occupation when he was mobilized with the National Guard, the National Guard later being made a part of the Army of the United States. The insured contends that within the meaning of said clause, he did not change his occupation. The facts are as follows:

At the time of the application for the insurance policy he was a member of the Washington National Guard, and he continued to maintain his membership in the Washington National Guard until February 3, 1941, when the Washington National Guard was mobilized, at which time he was granted a leave of absence from the post office. At the time of the accident, he was carried on the records of the post office as an employee on leave, and no one was hired permanently in his place. His seniority rights were protected, and his name continued on the retirement annuity records, and the payments he had made toward the retirement annuity were retained by the post office. He had paid into the annuity fund for almost nineteen years for retirement, and he had no intention of forfeiting such future security. His intention was to return to his work in the post office as soon as he was discharged from the army, and he would now be back in his employment if he were physically able to carry on work of any kind. His rights to return to his employment and to continue his occupation have of course been protected by veterans' legislation, which guarantees to him the right to return to his employment. It was the position of insured that a change of occupation requires a voluntary and intentional act whereby one occupation is abandoned and a new occupation chosen and followed. Insured was mobilized in the

Army of the United States as distinguished from the United States Army, the latter being the regular army, while the former is temporary and for the duration of the war.

If the insurer were correct in its assumption that the insured changed his occupation, it would be necessary to construe the meaning of the exception phrase of said cause reading: "or while he is doing any act or thing pertaining to any occupation so classified, *except ordinary duties about his residence or while engaged in recreation.*" (Italics added.) There is a controversy regarding the meaning of this phrase. As construed by the insured, it would except him from the change of occupation clause (if he had changed his occupation as insurer contended) since he was on leave or furlough at the time of the accident and "that his activities at the time of said injury had no causal connection with his occupation or any occupation; and that at said time he was engaged solely in recreation and was operating a personally owned motor vehicle for his own enjoyment, an act common to the lives of men without regard to occupation." (Tr. 15.)

4.

Total and Permanent Disability. There was a controversy regarding insured's total and permanent disability, but at the trial counsel for insured and for

insurer stipulated that insured was totally disabled from the date of accident to the date of trial without limitation or restriction as to future total disability (Tr. 60).

Section 274d of the Judicial Code, 28 U. S. C. A. Sec. 400, provides, in part:

> "(1) In cases of actual controversy * * * the courts of the United States shall have power upon petition * * * to declare rights and other legal relations of any interested party petitioning for such declaration * * * and such declaration shall have the force and effect of a final judgment or decree."

In *Aetna Life Insurance Co. vs. Haworth*, 300 U. S. 227, 57 S. Ct 461, 81 L. Ed. 617, the Supreme Court of the United States defined what is meant by "cases of actual controversy" under the Act, at page 240 of 300 U. S.:

> "A 'controversy' in this sense must be one that is appropriate for judicial determination. * * * A justiciable controversy is thus distinguished from a difference or dispute of a hypothetical or abstract character; from one that is academic or moot. * * * The controversy must be definite and concrete, touching the legal relations of parties having adverse legal interests. * * * It must be a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion advising what the law would be upon a hypothetical state of facts."

*Borchard*, in his book "*Declaratory Judgments*" (2d Ed.), says at page 56:

> "The danger or dilemma of the plaintiff must be present, not contingent on the happening of hypothetical future events—although it may involve future benefits or disadvantages—and the prejudice to his position must be actual and genuine and not merely possible or remote."

In *Aetna Life Ins. Co. vs. Williams*, 88 F. (2d) 929, it was held that *justiciable controversy* arises as to the amount due the beneficiary of an insurance policy, where the amount payable by the terms of the policy was to be reduced if the insured engaged in a more hazardous occupation, the insurer claiming that the insured at the time of his death, was engaged in a more hazardous occupation, and the beneficiary claiming the full amount of the policy.

A concrete dispute relating to the rights of the insured under the contract of insurance existed and the District Court had the judicial discretion to take jurisdiction of insured's action for a declaratory judgment adjudicating the parties' rights and obligations.

## III. Jurisdiction.

The Federal Declaratory Judgment Act does not itself contain any provision with reference to jurisdictional amounts. Where it appears evident that a just

determination may be attained, the court will not be lax in exercising its discretion in assuming jurisdiction.

The requisites of jurisdiction are: diversity of citizenship; justiciable controversy and the jurisdictional amount. Under the heading of justiciable controversy would be the construction of the meaning of the policy. Under the heading of jurisdictional amount would be considered the value of insured's rights, validity of the policy, face value, benefits and life expectancy.

a. Value of Rights to be Preserved and Protected.

The value of the right in dispute determines the jurisdiction of the Federal court, and it has been said that the exercise of jurisdiction under the declaratory judgment act under such circumstances, is not to extend the jurisdiction of the court but merely to hasten the day when jurisdiction may be invoked. The trial court in its memorandum opinion cites many cases which will not be repeated under this section.

b. Validity—Attempt to Vitiate Policy.

Where validity of the policy is being attacked, the face value of the policy may be added to the accrued benefits.

In *Stephenson vs. Equitable Life Assur. Soc.*, 92 F. (2d) 406, Judge Parker said at Page 410:

"The fact, that in addition to asking judgment declaring the rights of the parties in the premises, plaintiff asked a recovery of the past-due disability installments, does not detract from the power of the court to grant the declaratory relief. Upon the court's declaring the rights of the insured under the policy in accordance with his contentions, he would have been entitled to recover these installments; and the second paragraph of the act expressly provides for the granting of further relief whenever necessary or proper.

"And we think there can be no question but that the requisite jurisdictional amount was involved in the suit. This amount was not merely the unpaid disability installments, as the judge below erroneously thought, but also the $5,000 double indemnity feature of the policy which the company had declared void, and the $5,000 ordinary life feature, which the company had declared lapsed and for which it has substituted extended term insurance in that amount. *Bell v. Philadelphia Life Insurance Co., supra; Pacific Mutual Life Ins. Co. v. Parker* (CCA 4th) 71 F. (2d) 872, 874. The suit, therefore, involved the validity of a contract *for $5,000 of accident insurance* and the status of a contract for $5,000 of ordinary life insurance, in addition to the validity of the policy of disability insurance upon which the insured was claiming the past due installments of disability benefits. The case is clearly distinguishable from *Equitable Life Assurance Society v. Wilson* (C. C. A. 9th) 81 F. (2d) 657 *which involved merely the unpaid installments of disability benefits amounting to only $750.*" (Italics added.)

*Jensen vs. New York Life Ins. Co.*, 50 F. (2d) 512:

"In the case at bar, the policy contained a two-year incontestable clause, and the minimum face liability of the policy was shown to be $7,500.

"In the case of *Mutual Life Ins. Co. v. Thompson* (DC) 7 F. (2d) 753, 754, Judge McDowell, with forceful reasoning, reached the conclusion that in a suit to cancel an insurance policy, if the bill alleged that the 'value of the object sought by the bill', exclusive of interest and costs, exceeded the sum of $3,000, this was sufficient to confer jurisdiction.

* * *

"In *Elliott v. Empire Nat. Gas. Co.*, 4 F. (2d) 493, 497, an injunction case, this court, after reviewing many authorities, held that the 'value of the matter in controversy' in Judicial Code Sec. 24 (28 U. S. C. A. Sec. 41), means the pecuniary result to either party which the judgment entered in the case would directly produce, either at once or in the future.

"'Whether we apply, therefore, the test as laid down in the Fifth circuit, or the test suggested in the Fourth circuit by Judge McDowell, or the test suggested for analogous cases by this court in the Elliott Case, supra, and apparently followed by the trial court in the case at bar, the same result is reached that the requisite jurisdictional amount is involved, and that jurisdiction of the federal court existed."

*Pacific Mut. Life Ins. Co. vs. Parker*, 71 F. (2d) 872, 874. (Opinion by Judge Parker)

"We agree with appellant that the case involves the amount requisite to federal jurisdic-

> tion. What is asked by the bill is not merely that prosecution of the suits which have been instituted be restrained, but also that the policies be canceled and surrendered. As one of the policies provides for the payment of $5,000 in case of accidental death, and as the monthly payments for disability amount to $500 per month, which under the terms of the policies is to continue throughout the life of the insured, there would seem to be no question as to more than $3,000 being involved * * *."

Insurer in the present case is attempting to cancel a provision of the policy which had become incontestable under our state law.

At page 874 of the Parker case, *Supra*, it was said that an insurance policy, providing for payment in case of accidental death, is "life insurance policy" to such extent within state statute, prescribing incontestable period for such policies.

*Whitfield vs. Aetna Life Ins. Co.*, 205 U. S. 489, 498, 27 S. C. 578, 51 L. Ed. 895;

*Continental Casualty Co. vs. Agee* (C. C. A. 8th) 3 F. (2d) 978;

*Aetna Life Ins. Co. vs. Wertheimer* (C. C. A. 10th) 64 F. (2d) 438.

Our Washington statute, Sec. 7230 Rem. Rev. Stat., provides:

> "No life insurance policy, * * * shall be issued or delivered in this state on and after January

First, Nineteen Hundred and Twelve, unless it contains in substance the following provisions:

* * * * *

"(2) A provision that (the) policy, so far as it relates to life or endowment insurance shall be incontestable after two years from the date of issue except for non-payment of premiums, and except for violation of the conditions of the policy relating to military or naval service in time of war."

The face value of principal sum of said policy is $1000 payable in event of accidental death. In Schedule I, of said Star Accident Policy, it is provided:

"(a) If such injury shall continuously and wholly disable the Insured any time within two weeks from date of accident from performing any and every duty pertaining to his occupation, and during the period of such disability, shall result in one of the losses specified under SPECIFIC LOSSES, the Company will pay the sum set opposite such loss:

* * * *

"In ADDITION THE WEEKLY ACCIDENT INDEMNITY as provided in Schedule II between the date of accident and date of such loss; provided further, that not more than one of the amounts (the greater) named under SPECIFIC LOSSES shall be payable for injuries resulting from one accident.

"SPECIFIC LOSSES

"Loss of Life .....The Principal Sum"

Insurer is attempting to vitiate the policy of insurance by attacking the amount of the face value of the

policy which is incontestable and by asserting the benefits should be pro-rated to one-fifth of the amounts set forth in the written contract of insurance. Even if insured had changed his occupation as contended by insurer, the benefits of the policy could not be reduced inasmuch as insurer has not complied with the state law, and insurer's attempt to reduce benefits is an attempt to cancel.

c. Life Expectancy—Future Rights.

The trial court, in considering the value of future benefits was justified also in taking into consideration insured's life expectancy and was supported by numerous authorities. The trial court did not consider insured's life expectancy for the purpose of computation or compilation of future damages for the amount of a judgment; the trial court did not award future damages in its judgment. Total and permanent disability was alleged by the insured, who was 38 years old at the time of his injury, and consideration of life expectancy would be material in an action to protect and preserve the value of the rights of insured.

Among the many cases holding that life expectancy may be considered are the following:

In *Ballard et al. vs. Mutual Life Ins. Co. of New York*, 109 F. 2d 388, 389, the court said:

> "The declaratory action originally instituted by appellee (now pending in the court below) sought to relieve the plaintiff from the claim of the insured that he was entitled to receive disability payments and to have the policies maintained in force under the disability provisions thereof without payment of premiums thereon. This claim (from the asserted liability for which the plaintiff asked to be relieved) was alleged to be in excess of $3,000, and since the insured is only forty-two years of age, has a reasonable life expectancy of many years, and is alleged to be totally and permanently disabled, it appears to us that the value of his claim is not overstated. The amount in controversy is the value of the claim which the company is seeking to have cancelled in the court below, not the amounts sued for in the state courts."

*Mutual Ben. Health & Accident Ass'n vs. Fortenberry*, 98 F. (2d) 570, held that the obligations which the insurer might be compelled to pay in the future were not merely contingent and would enter into the amount in dispute, regarding federal court's jurisdiction on ground of diversity of citizenship, of suit to cancel life, accident, and health policy. In determining obligations the insurer might be compelled to pay in the future, which would enter into amount in dispute, the life expectancy of the insured could be considered.

*Thompson vs. Thompson*, 226 U. S. 551, 33 S. Ct. 129, 57 L. Ed. 347.

*Brotherhood of Locomotive Firemen and Enginemen vs. Pinkston*, 293 U. S. 96, 55 S. Ct. 1, 79 L. Ed. 219;

*New York Life Ins. Co. vs. Swift*, 5 Cir., 38 F. 2d 175;

*Jensen vs. New York Life Ins. Co.*, 8 Cir., 50 F. 2d 512.

In the authorities cited by insurer, future damages were asked to be made a part of the judgment. The circumstances differed from the present case.

Insurer cited the case of *Travelers Ins. Co. vs. Wechler*, 34 F. Supp. 721, in its brief. In the Wechler case there is considerable discussion of the difference between it and *Aetna Life Ins. Co. vs. Haworth*, 300 U. S. 227, *Ballard vs. Mut. Life Ins. Co., and Mut. Health & Acc. Ass'n vs. Fortenberry, supra.* The court said:

> "In the absence of a showing, or effort, to cancel the policies * * * or in the absence of allegations of lapse of the policies by failure to pay premiums, or *in the absence of an admission of total and permanent disability, but in denial thereof*, it is difficult to see how the life expectancy of the assured, multiplied by the yearly disability benefits contained in the policies, or the reserve to be maintained under the policies, could either be computed to supply the requisite amount in controversy." (Italics added.)

To the quotation from the opinion in the case of *Mitchell vs. Mutual Life Insurance Co. of New York*, 31 F. Supp. 441, cited by insurer, insured wishes to add the following from page 444 of that opinion:

> "Moreover the parties litigant in this case are not trying to vitiate the contract of insurance between them."

During the trial the insured testified as to his age. The accident policy (made an exhibit in this case) had attached thereto a copy of the insured's application in which his age was stated.

> "Judicial notice will be taken * * * of the average duration and expectancy of human life, and of the Northhampton and American tables of mortality. * * *" *Jones Commentaries on Evidence*, Vol. I. Sec. 129, Page 630.

And on page 649, Sec. 134 A:

> "It is hardly necessary to add that no evidence need be given of those facts of which the court should take judicial notice. * * * It has been held repeatedly that the court may refuse to hear evidence concerning that of which it will take judicial notice. * * *"

Page 654:

> "* * * There is no necessity either to plead or prove any fact of which judicial notice will be taken, since it is the very essence of such facts that they are common knowledge. * * *"

d. Cases Cited by Insurer Relating to Jurisdiction

The authorities cited by insurer supporting its statement that there was not $3000.00, exclusive of interest and costs, in controversy when suit was commenced, very clearly have no application to the present

action. A careful survey of the cases on this subject reveals the facts are not similar. In this case the insurer is attempting to cancel and void portions of the policy. Insured is asking a declaration of the meaning of the policy and that the value of rights are to be preserved and protected.

The first case cited by insurer, *Mutual Life Insurance Co. of New York vs. Temple*, 56 F. Supp. 737, was an action at law to recover payments rather than a suit in equity to preserve and protect value of right. The litigants were not trying to vitiate the policy. The only question being total and permanent disability and the accrued benefits amounted to $200.

*Elgin vs. Marshall*, 106 U. S. 578, 1 S. Ct. 488, 27 L. Ed. 249, was not a declaratory judgment action. Insurer quotes from opinion which holds cases involving rights are excluded. Sec. 274d of the Judicial Code 28 U. S. C. A. Sec. 400, however, provides that the courts of the United States shall have power "to declare rights and other legal relations of any interested party petitioning for such declaration."

The case of *New England Mortgage Co. vs. Gay*, 145, U. S. 123, 12 S. Ct. 815, 36 L. Ed. 646, was merely an action in assumpsit.

*Gibson vs. Shufeld*, 122 U. S. 27, 7 S. Ct. 1066, 30 L. Ed. 1083. General creditors in this action sued to set

aside conveyance as fraudulent. Therein it was said that one suit of several plaintiffs or defendants who might have sued or been sued in separate actions does not enlarge the appellate jurisdiction.

*Mutual Life Ins. Co. of New York vs. Moyle,* 116 F. 2d 434. It is difficult to believe insurer is seriously asserting that the Moyle case and instant case are "virtually identical." Judge Parker clearly distinguishes the difference between the Moyle case involving only the right of the insured to the accrued disability payments from one where the controversy relates to the validity *or meaning* of the policy. It was said in the Moyle case:

> "No controversy is alleged to exist as to the validity of the policies, but, on the contrary, plaintiff itself avers that they are valid obligations and are in full force and effect. *Nor is there any controversy as to the meaning of the policies.*" (Italics added.)

Judge Parker wrote opinions in other cases holding the court entertained jurisdiction when the validity and meaning of the policy were involved.

In *Wright vs. Mutual Life Insurance Co. of New York,* 19 F. 2d 117 and *Mutual Life Insurance Co. of New York vs. Wright,* 276 U. S. 602, 48 S. Ct. 373, 72 L. Ed. 726, the only disputed question of fact was whether the insured committed suicide or died as the

result of an accident in an action for insurance installments.

In *Button vs. Mutual Life Insurance Co. of New York*, 48 F. Supp. 168, insured sought to recover total permanent disability benefits amounting to $700. Validity of policy not questioned nor construction of meaning asked.

*Equitable Life Assur. Soc. of the United States vs. Wilson*, 81 F. 2d 657. In this case there was no prayer for general relief and no pleading for declaratory relief under 28 U. S. C. A. Sec. 400.

The court said:

> "All that appears from the complaint is that there is a policy in full force and effect which created two insurances, one on the life of the insured and the other on his disability. No claim is made under the life insurance, and the only claim that is made is that $750 is due on the disability payments and unpaid by the defendant."

Nearly all of these cases were cited to the trial court and argued by insurer in its motion to dismiss for lack of jurisdiction and were considered by the trial court in its memorandum opinion, which opinion is as follows:

> "This is an action under the Federal Declaratory Judgment Act (28 U. S. C. A. 400) in which plaintiff seeks to require defendant to pay hospital expenses and weekly disability allowances

under the provisions of a policy of insurance issued by the defendant to him in 1937. Plaintiff alleges that, while the policy was in force, he became totally and permanently disabled as a result of an accident occurring on April 14, 1943. He alleges that he has a life expectancy of 29.62 years and that, under the terms of the policy, he will be entitled during his life to receive benefits amounting to $35,400. He alleges that, up to the date of the filing of his amended complaint, benefits accrued to the extent of $2,575. He further alleges that the defendant refuses to pay the benefits provided in the policy for the reason that it contends that prior to the accident he had changed his occupation and that, under the provisions of the policy, the liability of the defendant is limited to such portion of indemnities provided in the policy as the premium paid would have purchased at the rate but within the limits fixed by the company for more hazardous occupation, which plaintiff alleges would be so limited in scope and value as almost to nullify any benefits. He alleges that his rights to future benefits which he seeks to preserve and protect by this action exceed the sum of $3,000 in value. To the complaint, the defendant has interposed a demurrer and a motion to quash. By those it seeks to raise the jurisdictional question as to whether the amount in controversy exceeds $3,000. Plaintiff objects to the consideration of this jurisdictional question under the demurrer and motion contending that they do not properly reach the question (28 U. S. C. A. 723 C-7 (c) and 126). Regardless of the tactical ineptness on defendant's part, the question is here and must be decided. *Kavourgias vs. Nicholaou Company Limited*, 9th Cir., decided March 12, 1945.

"Defendant insists that consideration of this jurisdictional question must be limited exclusively

to the allegations of the original complaint. That contention is without merit. Federal Rules of Civil Procedure 15 C (28 U. S. C. A. 723 C, 15 (c)). *Culver vs. Bell & Loffland*, 146 F. 2d 29, 31; *Alderman vs. Elgin J. & E. Ry Co.*, 125 F. 2d 971, 973; *International Ladies' Garment Workers' Union vs. Donnelly Garment Co.*, 121 F. 2d 561, 562; *Carr vs. Fife*, 156 U. S. 494, while it is true that, in determining jurisdiction, the decision must be based upon the facts that existed at the time of the commencement of the original action and it is true that a plaintiff cannot commence an entirely different action by an amended complaint, a plaintiff does have a right to insert new allegations of facts which existed at the time of the filing of the original complaint and they will relate back to the original filing. The only important factual amendment in the amended complaint here, as compared with the original, is the inclusion of the paragraph referring to plaintiff's life expectancy.

"'The problem which defendant presents on the question of jurisdiction is an extremely perplexing and vexatious one. There is a sharp conflict of opinion between the Circuit Courts of Appeals which have passed on it. The question posed is whether, in a declaratory judgment action, when the indemnities already accrued are less than $3,000, the court has jurisdiction when it is alleged that, taking into consideration the insured's life expectancy and accepting the allegation as to permanent and total disability, the value of the insured's rights will, if he lives out and is totally disabled during a sufficient period of his expectancy, amount to more than $3,000.

"It is well settled that, in a straight action to recover disability benefits, the jurisdictional amount must be measured upon the basis of the

indemnities already accrued. *Mutual Life Insurance Co. of New York vs. Wright*, 276 U. S. 602; *Equitable Life Assur. Society vs. Wilson*, 81 F. 2d 657; *Wright vs. Mutual Life Ins. Co. of New York*, 19 F. 2d 117. This is true even though the collateral effect of the judgment in such actions may be to establish the right of the insured to recover sums far in excess of the jurisdictional amount. *Elgin vs. Marshall*, 106 U. S. 578; *Cromwell vs. County of Sac*, 94 U. S. 351. See, also, *Healy vs. Ratta*, 292 U. S. 263. The Declaratory Judgment Act does not enlarge the jurisdiction of the Federal Courts nor alter the character of the controversies which are the subject of judicial power under the Constitution. *Southern Pacific Co. vs. McAdoo*, 82 F. 2d 121; *West Pub. Co. vs. Colgan*, 138 F. 2d 320. But when the validity of the whole policy is in issue and the policy value exceeds the jurisdictional amount, the court has jurisdiction in a declaratory judgment action even though the accrued liability for disability payments is less than $3,000. *Bell vs. Philadelphia Life Ins. Co.* 78 F. 2d 322; *Pacific Mut. Life Ins. Co. of California vs. Parker*, 71 F. 2d 872; *Ginsburg vs. Pacific Mut. Life Ins. of California*, 69 F. 2d 97. In that aspect, obligations it may be compelled to pay in the future are not merely contingent and enter into the amount in dispute. In determining what they are, the life expectancy of the insured may be considered. *Thompson vs. Thompson*, 226 U. S. 551; *Brotherhood of Locomotive Firemen & Enginemen vs. Pinkston*, 293 U. S. 96; *New York Live Ins. Co. vs. Swift*, 38 F. 2d 175; *Jensen vs. New York Life Ins. Co.* 50 F. 2d 512.

"The Court's jurisdiction in cases in which the basic facts substantially corresponded to those alleged here has been sustained in *Ballard vs. Mutual Life Ins. Co. of N. Y.*, 5th Cir., 109 F. 2d 388;

*Franzon vs. E. I. Du Pont de Nemours & Co.*, 3d Cir., 146 F. 2d 837; *Columbian Nat. Life Ins. Company vs. Goldberg*, 6th Cir., 138 F. 2d 192. See, also, *Davis vs. American Foundry Equipment Co.*, 7th Cir., 94 F. 2d 441. It has been denied in *Mutual Life Ins. Co. of New York vs. Moyle*, 4th Cir., 116 F. 2d 434; *Mutual Life Ins. Co. vs. Temple*, 56 F. Supp. 737; *Edelmann vs. Travelers Ins. Co. of Hartford, Conn.*, 21 F. Supp. 209.

"Unfortunately this is not a question of which disposition can be made through the simple mathematical process of comparing the number of decisions. In *Mutal Life Ins. Co. vs. Moyle*, *supra*, Judge Parker wrote an opinion which cannot be ignored even in the face of the weight of authority. No one can deny the correctness of his statement that litigants 'may not be permitted, under the guise of seeking declaratory judgments, to drag into federal courts the litigation of claims over which, because involving less than the jurisdictional amount, it was never intended that the federal courts should have jurisdiction.' There is much logic in his statement: 'A declaratory judgment can be had, however, only with respect to a justiciable controversy; and the justiciable controversy here, as we have seen, extends only to the accrued disability benefits, as the conditions entitling insured to such benefits may change at any time.' I can see no logic, however, in distinguishing between cases in which the entire policy is attacked and that in which only the questions of the right to the benefits is raised. If the amount of disability benefits is too uncertain in one instance, it should be too uncertain in the other. 'The conditions entitling insured to such benefits may change at any time' regardless of whether the attack is on the whole contract or just a part of it. In thus holding, the Moyle case

runs counter to the Supreme Court's statement in *Aetna Life Insurance Co. vs. Haworth*, 300 U. S. 227, 242, which reads as follows: 'On the one side, the insured claimed that he had become totally and permanently disabled and hence was relieved of the obligation to continue the payment of premiums and was entitled to the stipulated disability benefits and to the continuance of the policies in force. The insured presented this claim formally, as required by the policies. It was a claim of a present, specific right. On the other side, the company made an equally definite claim that the alleged basic fact did not exist, that the insured was not totally and permanently disabled and had not been relieved of the duty to continue the payment of premiums, that in consequence the policies had lapsed, and that the company was thus freed from its obligation either to pay disability benefits or to continue the insurance in force. Such a dispute is manifestly susceptible of judicial determination. It calls not for an advisory opinion upon a hypothetical basis but for an adjudication of present right upon established facts.

" 'That the dispute turns upon questions of fact does not withdraw it, as the respondent seems to contend, from judicial cognizance. The legal consequences flow from the facts and it is the province of the courts to ascertain and find the facts in order to determine the legal consequences. That is every day practice.'

"On this phase of the case, I feel myself bound by the recent decision of the Ninth Circuit Court of Appeals in *American General Ins. Co. vs. Booze*, 146 F. 2d, 329, 331. That was an action for a declaratory judgment by an insurance company which asked the court to determine whether or not it was required to defend an action which

had been commenced against its assured. The amount of liability to which the insurance company might be subjected was undetermined. It might be less or much more than $3,000. In that case, the entire policy was not attacked. The insurance company admitted that its contract was in full force and effect. It alleged that the individual for whose death claim was made, was, at the time of his death, covered by the Workmen's Compensation Act of California and that, therefore, his heirs were not entitled to recover from the plaintiff's assured and, therefore, asked the court so to interpret its contract as to relieve it of the obligation to defend the action against its assured or to pay a judgment which might be rendered against him. The issue was raised that because there was no certainty that the amount of that judgment would exceed $3,000, therefore the amount in controversy did not exceed $3,000. Without discussion, the court disposed of the contention as being without merit.

"It is true that the policy in the Booze case obligated the company to pay up to $10,000. That however, was only the limit of its obligation. It was just the ceiling above which its contract could not go. That is a distinction which few courts have made but which must be made. It is usually only upon death or the happening of a certain event (such as the loss of an eye or a limb) that the company 'contracts' to pay a certain amount. The principal sum named to be paid in the event of the occurrence of other events or the existence of certain conditions is the limit of liability. For example, in the policy involved in this case, there are two equally important provisions for indemnity. The first is the 'Single Principal Sum $1,000.' The other is the 'Single Weekly Indemnity $25.' This plaintiff's claimed right under the policy is to have paid to him the

sum of $25 per week as long as he lives if he is permanently and totally disabled. That right has been placed in doubt by the Company's claim that he lost it because he changed his occupation. The amount in controversy is the value of that which it is sought to be declared free of doubt. It cannot be claimed with any logic that a difference may exist simply because of the manner in which that doubt has been raised. There is an actual controversy admitting of relief. The jurisdictional question turns on the value of the right which is controverted. The Ninth Circuit Court of Appeals definitely recognized this principle when, in *Equitable Life Assur. Co. vs. Wilson*, *supra*, p. 660, it underlined the Supreme Court's language as follows: 'The Supreme Court draws the distinction between the two in the following language: "This, it will be seen, is not an action at law to recover overdue installments, but a suit in equity to preserve and protect a right to future participation in the fund. If the value of that right exceeds $3,000, the District Court has jurisdiction." 293 U. S. 96, 99, 100, 55 S. Ct. 1, 2, 79, L. Ed. 219.'

"Defendant's demurrer, which I have considered as a motion to dismiss, must be overruled and its motion to quash denied."

### f. Federal Jurisdiction Depends on the Facts at the Time Suit Is Commenced.

Insured is in accord with the authorities cited by insurer to the effect that jurisdiction depends on the facts at the time suit is commenced, but not with insurer's statement that jurisdiction depends upon facts *alleged* when suit is commenced. This point is thor-

oughly discussed in the trial court's memorandum opinion.

## IV. Question of Pro-rating

The trial court held the case *Nordin vs. Commercial Casualty Ins. Co.*, 176 Wash. 59, 28 P. (2d) 259, is decisive of this case.

That case and the instant case are identical. In the Nordin case, as in the present case, the same insurer, the Commercial Casualty Ins. Co. was seeking to escape liability by virtue of the protection of the same statute.

In each case the liability of the insurer had been established, but the insurer was relying upon the pro-rating clause of the policy to enable it to reduce the amount of its liability to one-fifth or less of that stated in the written contract of insurance.

Since the accident policy in each case recited it was the *entire contract* of insurance, except as it may be modified by the company's classification of risks. It was necessary for the insurer to establish a classification of risks, filed with the commissioner, which modified *this policy*, as otherwise the indemnity provided in the contract would be unaffected.

The Washington law in Rem. Rev. Stat. 7233, provides that no accident insurance policy shall be issued or de-

livered until a copy of the form thereof and of the classification of risks *pertaining thereto* have been filed with the insurance commissioner. Said section reads as follows:

> "No policy of insurance against loss or damage from the sickness, or the bodily injury or death of the insured by accident shall be issued or delivered to any person in this state until a copy of the form thereof and the classification of risks, if more than one class of risks is written and the premium rates pertaining thereto have been filed with the insurance commissioner; * * *"

The only classification of risks filed by insurer either at the time of the Nordin case or up till April 14, 1943, is the black manual, filed May 29, 1929, "Plaintiff's Exhibit D" and that classification of risks does not *pertain* to the Star Accident Policy No. 14H 5110, just as it did not pertain to form 104-A in the Nordin case. Just as in the Nordin case, there is no proof that Star Accident Policy No. 14H 5110 is identical to the forms mentioned in the black manual to which the filed classification of risks apply. It will be noted that the black manual is so constructed that new matters may be added. At the front of the black manual containing the classification of risks is a list of forms of policies to which the classification of risks pertain. This does not include Star Accident Policy 14H 5110, Cas. A. & H. 5643.

The red manual, "Defendant's Exhibit I," is an instruction book for agents. It is prepared for distribution to all the agents of the several companies of the Loyalty Group of accident and health companies. The leaves are tightly bound and any addition is pasted in. The first page begins with:

"Underwriting Instructions
"Concerning
"Accident and Health Business

> "The Company's rules and instructions governing the conduct of the Commercial Accident and Health business will be found in the following pages. The Company reserves the right to change these rules at any time.
>
> "The rules, as issued should be carefully read by every agent. Lack of knowledge of the Company's instructions is the cause of much unnecessary correspondence, embarrassment and delay."

Counsel for insurer stated: "I contend that the red manual is the one upon which we have a right to depend." (Tr. 112.) But the Star Accident Policy No. 14H 5110 is not mentioned in the red manual and we are unable to understand in just what manner it could pertain to a policy not mentioned. Counsel for insured admitted that Star Accident Forms vary (Tr. 117).

It is contended by the insurer that it has complied with the above state statute, but there is no foundation for such contention.

The Star Accident Policy, No. 14H 5110 was filed with the insurance commissioner on June 3, 1929. Nearly sixteen months later the red manual was filed. That manual did not refer to the policy in suit and there is nothing to indicate that it was ever attached to said policy form, nor was it attached when the insurance commissioner's records were subpoenaed.

The insurer further asserts that it has only one classification of risks. It is improbable that the insurer has less classifications now than when the Nordin case was decided.

The insurer not having filed its classification of risks pertaining to the said policy, the trial court did not pass upon the question of change of occupation, just as the court did not pass upon that question in the identical case of *Nordin vs. Commercial Casualty Insurance Company, supra.*

The primary purpose of filing the classification of risks pertaining to each policy, is, under the statute, the only way in which the insurer can modify the written contract of insurance, since the relation between the insurer and insured is purely a contractual one. The policy in suit reads in part:

> "This policy * * * contains the entire contract of insurance, except as it may be modified by the company's classification of risks. * * *"

Quoting further from the Nordin case, at page 65:

"The policy recites in Section A, above quoted, that it is the *entire contract* of insurance, except as it may be modified by the company's classification of risks. * * * * * It will be remembered that the classification, when filed, must pertain to the form of policy issued. It was, therefore, incumbent upon respondent to establish a classification of risks, filed with the commissioner, which modified *this policy*, as otherwise the indemnity provided in the contract would be unaffected.

"It will be borne in mind that the policy here in suit is form 104-A. The respondent sought to prove, as it was required to do, that a copy of its classification of risks pertaining to form 104-A had been filed in accordance with law. The evidence, however, only establishes that the classification of risks as filed pertain to 'New Ultimate Accident Policy Form 2-H.' There is no evidence that a classification of risks pertaining to *form 104-A* had ever been filed or approved. *Form 2-H* does not appear in the record, and the evidence apprises us of nothing concerning either its form or its content. There was no proof that form 104-A and form 2-H were identical, or even similar. We can not assume that they were the same.

"It is a matter of common knowledge that many forms of policies are filed with the insurance commissioner by many different insurance companies, and that a particular company may, from time to time, successively file many different forms. Differences in classifications of risks may result from differences in forms of policies. Under the statute the form of classification of risks must *pertain* to the form of policy filed.

There must, therefore, be some record connection between the two.

"Respondent was seeking to escape liability in this case by virtue of the protection of the statute. To escape liability, it was necessary for it to bring its proof within its defense. This it failed to do. Its liability is, therefore, measured by the terms of the contract of insurance, unaffected by any extraneous and unconnected classification of risks not pertaining to the policy." (Emphasis by court.)

It is the further contention of insurer that if the opinion of the trial court is upheld, it would necessitate the filing of twenty or more red manuals with the insurance commissioner. The attention of the Honorable Court is respectfully directed to the black manual (plaintiff's exhibit "D").

In the front of this manual is a page upon which are designated the policy forms to which the classification of risks therein apply, and to comply with the statute, insurer need only file one new page with added form number to those already designated, and instruct the insurance commissioner to substitute such new page for the same numbered page in the black manual. Examination of the said manual will show this is the customary procedure in making any changes in such classification of risks, and usually the date is stamped on the new page.

In the above quoted case, policy form 2-H was not before the court, but in the present case all matters relating to the commercial accident and health policies of the insurer filed with the state insurance commissioner, were before the trial court. The trial court heard the testimony of witnesses and the argument of counsel relating to said records and, after examining the subpoenaed records, rendered its opinion, which is in part as follows:

> "I am not going to pass upon the question of the change of occupation, nor determine the question of whether or not it needs to be voluntary. I am expressing no opinion on that one way or the other, and I am not deciding the case upon the basis of estoppel, although I will say it occurs to me there was some obligation on the part of this company, knowing this man was in the National Guard, and knowing that the National Guard was mobilized in 1941, there was some obligation on its part to not accept the premiums from which he was to get $25.00 a week and not let him know if he got injured as he did here that they intended only to pay him $5.00 a week, and make certain mental reservations on it.
>
> "'I am deciding the case upon the basis of the Nordin case. Counsel refers to it as a technicality. It may be. If it was a technicality it was pointed out to this particular company very definitely and emphatically by the Supreme Court of the State of Washington, and they knew it was not a mere technicality before, and they should have complied with the requirements of the Supreme Court's ruling. I see no question about the company's

failure to comply with the statute as the statute has been interpreted by the Supreme Court.

"I am reading from *Nordin vs. Commercial Casualty Insurance Company*, 176 *Washington*, 64:

" 'The determinative feature of this case, as we view it, rests upon the respondent's failure to establish the fact that it had filed with the Insurance Commissioner of this state a copy of its classification of risks pertaining to the policy in suit, as required by the statute.

" '*Rem. Rev. Stat., Sec.* 7233, provides that no accident insurance policy shall be issued or delivered until a copy of the form thereof and of the classification of risks pertaining thereto have been filed with the Insurance Commissioner.

" 'Thus it will be seen that the policy is to be held a valid and binding contract, but, in so far as it conflicts with *Sec.* 7233, *supra*, the provisions of the latter shall govern. Expressed according to result, the policy does not draw to itself, as part thereof, any classification of risks therein referred to, unless a form of such classification pertaining to the particular policy has been filed in accordance with law.'

"Now counsel for the defendant takes the position that the defendant's exhibit '1' was controlling at the time the policy was issued.

"This is the manual of the Loyalty Group. It is not even a manual of this particular insurance company, but a manual of the Loyalty Group, of which this insurance company is a member, and it limits the risk on all policies issued by whatever companies are members of the Loyalty Group.

"The testimony of the witness from the Insurance Commissioner's office that they filed it with the Star policy at the time it was filed, must be construed to be an attempt to comply with the classification requirements pertaining to the policy, and not in a classification of the limitations of the risk. It has classes A, B, C and D, and is the premium rate for those accident policies. These other papers that were filed are nothing more than premium rates.

"I agree with Judge Askren that I cannot conceive of this company, having gone through this experience once, that they would turn around and do it just as bad over again, but after this case was decided in January, 1934, they had on file their manual for the whole Loyalty Group of insurance companies, not referring to any policy, and then they say that these papers they filed of statements of premium rates are sufficient to meet the requirements.

"It is true they did not have all the evidence before them in that case that they wanted to have, but you have all of it here, and there just isn't anything here that the statute was complied with and that they filed any classification pertaining to this policy. They didn't even file a classification of risks pertaining to the Commercial Casualty Insurance Company, but filed a general classification of risks for all the companies in the Loyalty Group.

The statement by the insurer that the state insurance commissioner was satisfied with the purported filing of classification of risks by the insurer stands unsupported, but even if true, it is a well-established principle of law that no state officer or employee has

the power to waive compliance with the statutes of the state.

It is respectfully submitted that the district court was acting entirely within its judicial discretion in assuming jurisdiction in this case; and further, under the case of *Erie vs. Tompkins*, 304 U. S. 64, 82 L. Ed. 1188, 58 S. Ct. 817, it was the duty of the Federal court to follow the state decision in the case of *Nordin vs. Commercial Casualty Insurance Company*, 176 Wash. 59.

Respectfully submitted,

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